

April 4th, when he was discharged cured, the patient continued to do well, being free from pain, and the swelling, which consisted of œdema of the scrotum and inflammatory enlargement of the testicle, had almost entirely disappeared, only slight thickening of the latter still remaining. The wound was completely healed and he could walk about without discomfort or inconvenience of any kind. On making him stand and cough no impulse or tendency to return of the hernia could be felt. The patient stated that previously to the operation he could not stand without the bowel coming down. He was carefully examined by Surgeon-Captain J. Jackson, I.M.S., and myself previously to being discharged, and we both came to the conclusion that so far as could be seen the case was one of radical cure of hernia due to the inflammatory action which had occurred.

The two interesting features in this case are the sudden enlargement of the scrotum following the operation, which at first sight might have been mistaken for a return of the hernia, and the, to all appearances, radical cure which followed the inflammation.

Satara, India.

## Clinical Notes :

### MEDICAL, SURGICAL, OBSTETRICAL AND THERAPEUTICAL.

#### PUERPERAL FEVER OR TYPHOID FEVER?

BY G. A. VAN SOMEREN, M.D. EDIN.

ON Feb. 28th I was sent for to see a patient, and on arrival I found that she had had a severe rigor, from which she had just come round and was perspiring profusely. Taking the temperature, I found it to be as high as 104.5° F. On inquiry I ascertained that she was pregnant and expected to be confined every day, having passed the time she had calculated upon. I also learned that she had been ill and out of sorts for the past nine or ten days, suffering from headache, pains in the back and limbs, diarrhoea and want of appetite. As typhoid fever was prevalent I thought it well to be on my guard, though feeling puzzled as to the occurrence of such a rigor at this stage. I could ascertain nothing else pointing to typhoid fever. There was no gurgling at the iliac fossa and no rose spots. I prescribed quinine, sulphuric acid and nux vomica and warned the friends that probably the confinement would soon take place, when I was to be sent for. I may say that there were no signs whatever of labour at this period. The next day I visited the patient and found that she had been confined at six that morning. There had been a second rigor at 2 A.M. She seemed well and cheerful and the temperature was 99.3°. The pulse, however, was quick. I asked the nurse if all the afterbirth had come away and was assured it had. Not having been sent for at the confinement I concluded that my further services would not be required and took my leave. This was on March 1st. I heard no more of the case till March 7th, when I was again sent for and found the patient in a very low state, with quick, thready pulse, colliquative sweats, extreme pallor, and constipation, the temperature being 101.4°, but the discharge was "all right" the nurse assured me. I again inquired concerning the afterbirth and was assured that it all came away. I at once ordered stimulants and prescribed the mixture originally ordered. The patient's whole mind was concentrated on a pain at the root of the nose and over the eyes, to which she never ceased to draw my attention and for which she was urgent to get relief. She had a hard hacking cough with tenacious sputum. A few days later she developed fainting fits, and it looked as if the heart would fail altogether, so I ordered a digitalis, nux vomica and sulphuric ether mixture, which acted very efficiently. My suspicions, however, were by no means allayed as to the question of the entire expulsion of the afterbirth, and these were strengthened and confirmed by the coming away of a piece of the placenta and the supervention of an offensive discharge. As my patient seemed to be in a very precarious condition, I determined to open and thoroughly explore the uterus. Douching the vagina well with a hot corrosive sublimate solution and anointing my finger and hand with eucalyptus ointment, I introduced my hand into the vagina and my finger into the uterus. I was soon able to force two fingers in, and found a mass of putrescent detritus, which I speedily removed, only to find more attached to the uterine fundus anteriorly, and for which I had to have recourse to the curette before I could properly detach and clear it out. This I finally succeeded in doing, and finished by giving the interior of the uterus a thorough and prolonged douching with hot iodine water. From this time the patient seemed to improve, though the colliquative sweats continued for a while and severe diarrhoea supervened, threatening indeed at one time to endanger life. I did not care to stop it entirely, viewing it as a salutary drain set up by the system for casting off impurities imbibed by the circulation. However, I ordered sulphate of copper with opium pills to keep the action of the bowels within bounds, which proved very successful. The discharge from the vagina soon became inoffensive and finally ceased altogether. The temperature, however, kept up for many days and did not become normal till March 28th. Before this I had begun to give tincture of iodine with carbolic acid, two drops every four hours, and that soon brought things down to the normal; the sweats quite passed away and the bowels became regular. The colour of the motions had been like that of pea soup, after a while they were grey like putty, and then became like those of a child. I will here give the dates approximately. I first saw the patient on Feb. 28th. She was confined on March 1st. I saw her again on March 7th and removed the remnants of the placenta on the 13th. I prescribed iodo-phenic acid on the 26th. The temperature was normal on the 28th. She got up on the 31st. Up to the time that I began the iodo-phenic acid the temperature kept above 101°; after that it steadily went down. Closer inquiries elicited the fact that the rigor in which I saw the patient was the second; she had had one before then, though not so severe. Thus she had three rigors before she was confined. That my patient had puerperal fever I consider there is not a shadow of a doubt, but was she sickening for something before then, and what was it? She is the first patient I have had with puerperal fever. Indeed, one rarely hears of it here, and that in spite of the fact that pieces of placenta and shreds of membrane are frequently left behind and require removal. In the very same week in which I was first called to this patient I had been sent for to see another woman, in whom there was post-partum hæmorrhage due to a large piece of placenta having been left behind by the midwife so-called, and removal of this was followed by a perfect recovery in a week without a bad sign attributable to it, and that notwithstanding my having had to operate without douche or anything but eucalyptus ointment; and this case does not stand alone. Why then did puerperal fever occur in the former case? My own impression is that whatever the patient had been sickening for had so weakened her vital forces and the resistive capacities of the tissues or the active capabilities of the phagocytes that she fell an easy victim to the microbes of putrefaction. But what was the nature of this affection? Was it typhoid fever? Is it conceivable that a person could resist successfully, as my patient did, the threefold danger of typhoid fever, childbed and puerperal fever? Of course, the nurse was speedily changed. Large quantities of brandy, liquor carnis, strong broths, milk and barley water, and milk and eggs were given, and she took nourishment well all through. She was sponged with cold water and vinegar as circumstances called for it, and was not allowed to exert herself. The child was bottle-fed from March 7th, and is doing well. Such is the record of this case. There are other points of interest in it, but I fear I have already trenched too much on valuable space.

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#### ON A CURE FOR "INCURABLE" METRORRAGHIA.

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In November, 1889, I saw with Mr. Holmes of Burmantofts a woman said to be suffering from endometritis. She was the wife of a miner, thirty-four years of age, and had had four children, the last ten years previously. Menstruation was very profuse and in the intervals she passed, to use her own words, "blood and corruption." The case had been for a long time in the hands of a medical man who had pre-

ceded Mr. Holmes in the care of the case. The patient was ultimately taken into the infirmary, as the loss of blood, which was the principal symptom, became greater. The uterus was, by the passage of the finger after dilatation, ascertained to be empty. The sound passed only two inches and a half. The uterus was exquisitely tender to touch. After exhausting all treatment likely to be of use, including very free curetting and the application of perchloride of iron to the uterine cavity, I ultimately in September of the following year removed the ovaries and tubes, with the view of arresting the loss of blood and relieving the pain. The patient was by this time a confirmed invalid. The tubes were in a state of chronic inflammation and the ovaries adherent, but not to the eye diseased in their interior. The patient after this improved and was by the end of three months able to do her housework. She then fell downstairs and hæmorrhage from the uterus recommenced. She was again admitted to the infirmary, but in spite of the use of perchloride of iron again and subsequently fuming nitric acid applied to the uterine cavity a daily hæmorrhage continued. I felt completely defeated and contemplated hysterectomy; knowing, however, the powers of chloride of zinc from constantly using it in the treatment of cancer, it occurred to me to apply this to the uterine cavity, with the view of causing a slough of the interior and so completely obliterating it. I therefore, after dilating the cervical canal once more, applied to the whole interior cotton wool wetted with the thickish fluid resulting from deliquescence of the sticks of solid chloride. This was wound round a piece of iron wire slightly curved at the end. The length of the cavity was first measured and the wool and chloride adapted accordingly; but the fluid was more sparingly spread on the wool at the proximal end, and it was so applied that it could not run off and overflow. The wire with its burden of wool was left *in situ* for twenty-four hours and then withdrawn. In the course of a fortnight a slough of the whole interior of the uterus came away about a quarter of an inch thick. The cavity became after this completely obliterated and the uterus correspondingly smaller and more shrunken in size. This of course cured the hæmorrhage, for there was no longer any place to bleed from. The patient was discharged much improved in health. As she had already undergone oöphorectomy, the loss of the uterine cavity was of no importance, but I can easily see how different the case would have been if the ovaries had been still active and intact. On reflecting upon this case it seemed to me that we might produce an action short of obliteration of the cavity by the use of this remedy and consisting of merely a superficial removal of the surface to a very slight extent, in cases of a desperate character in which other remedies failed.

On Oct. 23rd, 1892, I saw with Mr. Pickles of Leeds the wife of a tradesman fifty-five years of age. There had been no menopause or any signs of it; on the contrary, she had menstruated regularly every month up to April, 1891. The periods then commenced to be excessive, lasting fourteen days and sometimes only one week clear. This had gone on more or less until I saw her, but the hæmorrhage had become continuous. The uterus was freely curetted after dilatation. Nothing was removable except by such forcible pressure as to scrape away the mucous membrane itself. The organ was not materially enlarged, the sound passing two and three-quarter inches. The finger exploring the cavity detected nothing and bimanually no irregularity of outline or indication of fibroid could be detected. Chloride of zinc was applied to the interior for a few minutes, but the effect was found to be transient and ineffectual. Ultimately, on Feb. 21st last, the zinc was used with the object of destroying the interior and producing atresia. On April 14th I received a letter from Mr. Pickles to say that he found the interior of the organ quite closed. The patient was much better in consequence of the cessation of the hæmorrhage. I have had a number of cases in which the zinc has been applied for a few minutes only, but although a powerful styptic I have found it not permanently successful. It must either be used to produce atresia or not at all. Of course cases of such intractable hæmorrhage as to require such a remedy are very rare, and the remedy is, to a certain extent, an empirical one. It can only be applicable when a cause sufficient to explain the hæmorrhage cannot be found, and when the latter becomes dangerous to life. Still there are such cases, and there are a certain number on record in which the uterus has been removed entire after failure of all other treatment. The effect of atresia on the uterine cavity may be expected to be very different from that of removal of the uterine appendages. In the latter case

the menopause is artificially induced and consequently the system produces a less amount of blood than before the operation. When, however, the ovaries are not interfered with—as in the zinc treatment—the formation of blood continues undisturbed, and consequently it is more suitable when the system is exhausted by hæmorrhage. When a woman has bled beyond a certain amount she never recovers it completely, but remains anæmic and more or less an invalid for life. This plan of treatment affords a means of recovering the loss, for the formation of blood will continue as before. It is very important to use the thick fluid only which results from the deliquescence of the sticks; and it must have recently deliquesced, otherwise much of the zinc will be deposited and lost as carbonate. It is very liable to run over and into the vagina, and if so will produce a slough. To avoid this, a plug of cotton wool containing vaseline and carbonate of soda should be applied at the summit of the vagina; this quite neutralises any excess. Finally, I may say that in this treatment we have a resource—an ultimate resource—after the failure of everything else except hysterectomy; safe in application and effectual in accomplishing its end, but in itself undesirable and to be avoided unless life and health are very seriously threatened.

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### EXPECTORATION OF BRONCHIAL CASTS AFTER HÆMOPTYSIS IN PHTHISIS.

BY JAMES MANN WILLIAMSON, M.D. EDIN.

IN THE LANCET of May 20th, 1893, an interesting paper was published by Dr. R. W. Richards calling attention to the occasional expectoration of bronchial casts after hæmoptysis in phthisis. The fact that such a condition can actually occur, however rare it may be, deserves fuller recognition; and, keeping in mind the difficulties between phthisical hæmoptysis on the one hand and plastic bronchitis on the other, every instance seems to be worth recording. I have before me two branching, tree-like clots, evidently casts of a medium-sized bronchus, and exactly answering Dr. Richards' description. They are both from one patient and they readily attracted my attention in examining the blood that had been expectorated. Slight and transient hæmoptysis last February was the first sign of anything wrong with a chest which Dr. Ord had pronounced healthy in the previous November. The hæmorrhage recurred early in March, and it was then that the casts were coughed up. Extending over nearly a week there were several sudden, copious bleedings of from two to six ounces, each occupying only a few minutes, then disappearing entirely for several hours at a stretch, to recur time after time in the same explosive fashion. The loss of blood amounted altogether to not less than two pints. A succession of explosive attacks of hæmoptysis, separated by several hours of freedom, is often taken to indicate a cavity with an aneurysmal dilatation in its walls; but this need not be so; it can occur in the cases now under notice. In this individual patient there is no cavity. The disease at present (May) is limited to quite a small area at the left apex and still remains in a very early stage. The casts were not seen before the second day of the attack. They were red branching moulds of the bronchi, about two inches in their greatest length, having the consistence of soft jelly and preserving their form when removed into a bowl of water. To all appearance they were extensions downwards into the next bronchial subdivisions, of the clot which had formed against a rupture in a vessel in the bronchial lining. The peculiar shape and extent of the clot seemed best explained by supposing that the point of vascular rupture was at or near the angle of subdivision of a bronchus, where close and immediate apposition of a clot would not be so easily obtained as it would be midway along a bronchus. In my patient, a young lady of twenty-three, the temperature rose from normal to 102° on the second day of the bleeding, and it continued high not only throughout the week of the bleeding but for three weeks more. Since then it has followed a minor hectic range. Dr. Ord has seen the temperature rise from bronchial plugging, and the late Dr. Wilson Fox said that in plastic bronchitis there may be pyrexia in the early stages. The presence of the moulded clot in the bronchi may explain why my patient's temperature rose so abruptly during the